

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345277</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>03/13/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WOODLAND HILL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>400 VISION DRIVE</b> <b>ASHEBORO, NC 27203</b>
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{F 000}	INITIAL COMMENTS  On site follow-up was completed on 3/13/19. The tag F842 was recited. The facility is back in compliance effective 2/27/19	{F 000}		
{F 842} SS=C	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)  §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.  §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized  §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	{F 842}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 842}	<p>Continued From page 1</p> <p>neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, the facility failed to maintain complete medical records related to monitoring of placement and function of wanderguard (an electronic alert system that alarms and locks the facility exit</p>	{F 842}			

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{F 842}	<p>Continued From page 2</p> <p>doors when cognitively impaired residents with wandering behaviors attempt to exit the building) for 7 of 8 residents (Residents #3, #8, #15, #22, #23, #24, #25) sampled for complete and accurate medical records.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Resident #3 was admitted to the facility on 11/28/17 with diagnoses that included altered mental status, anxiety, and insomnia. The modification of a significant correction to a prior comprehensive Minimum Data Set (MDS) assessment dated 1/25/19 indicated Resident #3's cognition was severely impaired, and he had wandering behaviors on 1 to 3 days.</li> </ol> <p>A review of Resident #3's active physician's orders for March 2019 included an order for a wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) with the function and placement to be checked every shift. This order was placed on the Treatment Administration Record (TAR).</p> <p>A review of the March 2019 TAR from 3/1/19 through 3/12/19 indicated 3 instances that Resident #3's wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 3/1/19 (1st shift), 3/3/19 (3rd shift), and 3/9/19 (3rd shift).</p> <p>An interview was conducted with Nurse #1 on 3/13/19 at 3:13 PM. She stated she was familiar with Resident #3 and that he had an order for his wanderguard to be checked for function and placement every shift with documentation to be</p>	{F 842}			

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{F 842}	<p>Continued From page 3</p> <p>completed on the TAR. She revealed that Resident #3 had an unsupervised exit from the facility in the past. Nurse #1 stated she worked with Resident #3 on 3/1/19 during the 1st shift. The TAR for 3/1/19 that revealed no documentation by Nurse #1 of Resident #3 ' s wanderguard being checked for function or placement for the 1st shift was reviewed with Nurse #1. She stated she had completed the task but must have forgotten to initial the TAR that day. She revealed she had recently received an inservice on the importance of complete and accurate documentation related to wanderguard monitoring. She was unable to explain why she had not completed this documentation.</p> <p>A phone interview was conducted with Nurse #2 on 3/13/19 at 3:45 PM. She stated she was familiar with Resident #3 and that he had an order for his wanderguard to be checked for function and placement every shift with documentation to be completed on the TAR. She indicated she worked with Resident #3 on 3/3/19 and 3/9/19 during the 3rd shift. The TAR for 3/3/19 and 3/9/19 that revealed no documentation by Nurse #2 of Resident #3 ' s wanderguard being checked for function or placement for the 3rd shift was reviewed with Nurse #2. She stated she had completed the task but must have forgotten to initial the TAR on those dates. She reported that sometimes, if she worked a double shift, that she only initialed the TAR once to account for both shifts. She revealed she had recently received an inservice on the importance of complete and accurate documentation related to wanderguard monitoring. She was unable to explain why she had not completed this documentation.</p>	{F 842}			

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{F 842}	<p>Continued From page 4</p> <p>An interview was conducted with the Director of Nursing (DON) on 3/13/19 at 3:53 PM. She stated that wanderguard monitoring for function and placement was to be completed and documented on the TAR once on the 7:00 AM to 3:00 PM shift, once on the 3:00 PM to 11:00 PM shift, and once on the 11:00 PM to 7:00 AM. She indicated that if a nurse worked a double shift they were supposed to complete the task twice and document this on the TAR twice. The DON revealed she was responsible for monitoring the TARs to ensure documentation of wanderguard monitoring was completed three times daily. She stated that she had gotten behind on the monitoring audits this month and had just reviewed the March 2019 TARs on 3/12/19 and identified documentation that was incomplete. The DON also revealed that 7 of 8 residents in the facility with wanderguards had at least once one missed documentation of wanderguard monitoring for function and placement on their March 2019 TAR. She stated that her expectation was for this documentation to be fully completed.</p> <p>2. Resident #15 was admitted to the facility on 4/27/16 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 2/4/19 indicated Resident #15 's cognition was moderately impaired, and she had no wandering behaviors.</p> <p>A nursing note dated 3/7/19 indicated Resident #15 was overheard asking for the location of her car and stated that she needed to leave.</p> <p>A physician ' s order for Resident #15 dated 3/7/19 indicated an order for a wanderguard with the function and placement to be checked every</p>	{F 842}			

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{F 842}	<p>Continued From page 5 shift. This order was placed on the Treatment Administration Record (TAR).</p> <p>A review of the March 2019 TAR from 3/7/19 through 3/12/19 indicated 2 instances that Resident #15 ' s wanderguard check for function and placement was not initialed as complete. The date and shifts were as follows: 3/9/19 (2nd shift) and 3/9/19 (3rd shift).</p> <p>An interview was conducted with Nurse #3 on 3/13/19 at 3:00 PM. She stated she was familiar with Resident #15 and that she had an order for her wanderguard to be checked for function and placement every shift with documentation to be completed on the TAR. She indicated she worked with Resident #15 on 3/9/19 during the 3rd shift. The TAR for 3/9/19 that revealed no documentation by Nurse #3 of Resident #15 ' s wanderguard being checked for function or placement for the 3rd shift was reviewed with Nurse #3. She stated she had completed the task but must have forgotten to initial the TAR on that date. She revealed she had recently received an inservice on the importance of complete and accurate documentation related to wanderguard monitoring. She was unable to explain why she had not completed this documentation.</p> <p>An interview was conducted with the Director of Nursing (DON) on 3/13/19 at 3:53 PM. She stated that wanderguard monitoring for function and placement was to be completed and documented on the TAR once on the 7:00 AM to 3:00 PM shift, once on the 3:00 PM to 11:00 PM shift, and once on the 11:00 PM to 7:00 AM. The DON revealed she was responsible for monitoring the TARs to ensure documentation of</p>	{F 842}			

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{F 842}	<p>Continued From page 6</p> <p>wanderguard monitoring was completed three times daily. She stated that she had gotten behind on the monitoring audits this month and had just reviewed the March 2019 TARs on 3/12/19 and identified documentation that was incomplete. The DON also revealed that 7 of 8 residents in the facility with wanderguards had at least once one missed documentation of wanderguard monitoring for function and placement on their March 2019 TAR. She stated that her expectation was for this documentation to be fully completed.</p> <p>3. Resident #25 was admitted to the facility on 3/7/16 with diagnoses that included dementia. The modified quarterly Minimum Data Set (MDS) assessment dated 2/4/19 indicated Resident #25 ' s cognition was severely impaired, and she had wandering behaviors daily.</p> <p>A review of Resident #25 ' s active physician ' s orders for March 2019 included an order for a wanderguard with the function and placement to be checked every shift. This order was placed on the Treatment Administration Record (TAR).</p> <p>A review of the March 2019 TAR from 3/1/19 through 3/12/19 indicated 2 instances that Resident #25 ' s wanderguard check for function and placement was not initialed as complete. The date and shifts were as follows: 3/9/19 (2nd shift) and 3/9/19 (3rd shift).</p> <p>An interview was conducted with Nurse #3 on 3/13/19 at 3:00 PM. She stated she was familiar with Resident #25 and that she had an order for her wanderguard to be checked for function and placement every shift with documentation to be completed on the TAR. She indicated she</p>	{F 842}			

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{F 842}	<p>Continued From page 7</p> <p>worked with Resident #25 on 3/9/19 during the 3rd shift. The TAR for 3/9/19 that revealed no documentation by Nurse #3 of Resident #25 ' s wanderguard being checked for function or placement for the 3rd shift was reviewed with Nurse #3. She stated she had completed the task but must have forgotten to initial the TAR on that date. She revealed she had recently received an inservice on the importance of complete and accurate documentation related to wanderguard monitoring. She was unable to explain why she had not completed this documentation.</p> <p>An interview was conducted with the Director of Nursing (DON) on 3/13/19 at 3:53 PM. She stated that wanderguard monitoring for function and placement was to be completed and documented on the TAR once on the 7:00 AM to 3:00 PM shift, once on the 3:00 PM to 11:00 PM shift, and once on the 11:00 PM to 7:00 AM. The DON revealed she was responsible for monitoring the TARs to ensure documentation of wanderguard monitoring was completed three times daily. She stated that she had gotten behind on the monitoring audits this month and had just reviewed the March 2019 TARs on 3/12/19 and identified documentation that was incomplete. The DON also revealed that 7 of 8 residents in the facility with wanderguards had at least once one missed documentation of wanderguard monitoring for function and placement on their March 2019 TAR. She stated that her expectation was for this documentation to be fully completed.</p> <p>4. Resident #8 was admitted to the facility on 11/28/18 with diagnoses that included dementia.</p>	{F 842}			



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{F 842}	<p>Continued From page 8</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 2/12/19 indicated Resident #8 ' s cognition was severely impaired, and she had wandering behaviors daily.</p> <p>A review of Resident #8 ' s active physician ' s orders for March 2019 included an order for a wanderguard with the function and placement to be checked every shift. This order was placed on the Treatment Administration Record (TAR).</p> <p>A review of the March 2019 TAR from 3/1/19 through 3/12/19 indicated 2 instances that Resident #8 ' s wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 3/9/19 (3rd shift) and 3/10/19 (3rd shift).</p> <p>An interview was conducted with Nurse #3 on 3/13/19 at 3:00 PM. She stated she was familiar with Resident #8 and that she had an order for her wanderguard to be checked for function and placement every shift with documentation to be completed on the TAR. She indicated she worked with Resident #8 on 3/9/19 during the 3rd shift. The TAR for 3/9/19 that revealed no documentation by Nurse #3 of Resident #8 ' s wanderguard being checked for function or placement for the 3rd shift was reviewed with Nurse #3. She stated she had completed the task but must have forgotten to initial the TAR on that date. She revealed she had recently received an inservice on the importance of complete and accurate documentation related to wanderguard monitoring. She was unable to explain why she had not completed this documentation.</p> <p>An interview was conducted with the Director of</p>	{F 842}			

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{F 842}	<p>Continued From page 9</p> <p>Nursing (DON) on 3/13/19 at 3:53 PM. She stated that wanderguard monitoring for function and placement was to be completed and documented on the TAR once on the 7:00 AM to 3:00 PM shift, once on the 3:00 PM to 11:00 PM shift, and once on the 11:00 PM to 7:00 AM. The DON revealed she was responsible for monitoring the TARs to ensure documentation of wanderguard monitoring was completed three times daily. She stated that she had gotten behind on the monitoring audits this month and had just reviewed the March 2019 TARs on 3/12/19 and identified documentation that was incomplete. The DON also revealed that 7 of 8 residents in the facility with wanderguards had at least once one missed documentation of wanderguard monitoring for function and placement on their March 2019 TAR. She stated that her expectation was for this documentation to be fully completed.</p> <p>5. Resident #24 was most recently readmitted to the facility on 7/20/17 with diagnoses that included dementia. The annual Minimum Data Set (MDS) assessment dated 1/9/19 indicated Resident #24 ' s cognition was severely impaired, and she had no wandering behaviors.</p> <p>A review of Resident #24 ' s active physician ' s orders for March 2019 included an order for a wanderguard with the function and placement to be checked every shift. This order was placed on the Treatment Administration Record (TAR).</p> <p>A review of the March 2019 TAR from 3/1/19 through 3/12/19 indicated 2 instances that Resident #24 ' s wanderguard check for function and placement was not initialed as complete.</p>	{F 842}			

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{F 842}	<p>Continued From page 10</p> <p>These dates and shifts were as follows: 3/9/19 (3rd shift) and 3/10/19 (3rd shift).</p> <p>An interview was conducted with Nurse #3 on 3/13/19 at 3:00 PM. She stated she was familiar with Resident #24 and that she had an order for her wanderguard to be checked for function and placement every shift with documentation to be completed on the TAR. She indicated she worked with Resident #24 on 3/9/19 during the 3rd shift. The TAR for 3/9/19 that revealed no documentation by Nurse #3 of Resident #24 's wanderguard being checked for function or placement for the 3rd shift was reviewed with Nurse #3. She stated she had completed the task but must have forgotten to initial the TAR on that date. She revealed she had recently received an inservice on the importance of complete and accurate documentation related to wanderguard monitoring. She was unable to explain why she had not completed this documentation.</p> <p>An interview was conducted with the Director of Nursing (DON) on 3/13/19 at 3:53 PM. She stated that wanderguard monitoring for function and placement was to be completed and documented on the TAR once on the 7:00 AM to 3:00 PM shift, once on the 3:00 PM to 11:00 PM shift, and once on the 11:00 PM to 7:00 AM. The DON revealed she was responsible for monitoring the TARs to ensure documentation of wanderguard monitoring was completed three times daily. She stated that she had gotten behind on the monitoring audits this month and had just reviewed the March 2019 TARs on 3/12/19 and identified documentation that was incomplete. The DON also revealed that 7 of 8 residents in the facility with wanderguards had at</p>	{F 842}			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345277</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>03/13/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>WOODLAND HILL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>400 VISION DRIVE ASHEBORO, NC 27203</b>		
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{F 842}	<p>Continued From page 11</p> <p>least once missed documentation of wanderguard monitoring for function and placement on their March 2019 TAR. She stated that her expectation was for this documentation to be fully completed.</p> <p>6. Resident #23 was admitted to the facility on 10/31/18 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 2/19/19 indicated Resident #23 ' s cognition was severely impaired, and she had no wandering behaviors.</p> <p>A review of Resident #23 ' s active physician ' s orders for March 2019 included an order for a wanderguard with the function and placement to be checked every shift. This order was placed on the Treatment Administration Record (TAR).</p> <p>A review of the March 2019 TAR from 3/1/19 through 3/12/19 indicated 2 instances that Resident #23 ' s wanderguard check for function and placement was not initialed as complete. The date and shifts were as follows: 3/9/19 (2nd shift) and 3/9/19 (3rd shift).</p> <p>An interview was conducted with Nurse #3 on 3/13/19 at 3:00 PM. She stated she was familiar with Resident #23 and that she had an order for her wanderguard to be checked for function and placement every shift with documentation to be completed on the TAR. She indicated she worked with Resident #23 on 3/9/19 during the 3rd shift. The TAR for 3/9/19 that revealed no documentation by Nurse #3 of Resident #23 ' s wanderguard being checked for function or placement for the 3rd shift was reviewed with Nurse #3. She stated she had completed the</p>	{F 842}			

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{F 842}	<p>Continued From page 12</p> <p>task but must have forgotten to initial the TAR on that date. She revealed she had recently received an inservice on the importance of complete and accurate documentation related to wanderguard monitoring. She was unable to explain why she had not completed this documentation.</p> <p>An interview was conducted with the Director of Nursing (DON) on 3/13/19 at 3:53 PM. She stated that wanderguard monitoring for function and placement was to be completed and documented on the TAR once on the 7:00 AM to 3:00 PM shift, once on the 3:00 PM to 11:00 PM shift, and once on the 11:00 PM to 7:00 AM. The DON revealed she was responsible for monitoring the TARs to ensure documentation of wanderguard monitoring was completed three times daily. She stated that she had gotten behind on the monitoring audits this month and had just reviewed the March 2019 TARs on 3/12/19 and identified documentation that was incomplete. The DON also revealed that 7 of 8 residents in the facility with wanderguards had at least once one missed documentation of wanderguard monitoring for function and placement on their March 2019 TAR. She stated that her expectation was for this documentation to be fully completed.</p> <p>7. Resident #22 was admitted to the facility on 11/13/18 with diagnoses that included dementia. The modification of a significant change in status Minimum Data Set (MDS) assessment dated 1/30/19 indicated Resident #22 ' s cognition was severely impaired, and she had no wandering behaviors.</p>	{F 842}			

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{F 842}	Continued From page 13  A review of Resident #22 ' s active physician ' s orders for March 2019 included an order for a wanderguard with the function and placement to be checked every shift. This order was placed on the Treatment Administration Record (TAR).  A review of the March 2019 TAR from 3/1/19 through 3/12/19 indicated 1 instance on 3/9/19 for the 3rd shift that Resident #22 ' s wanderguard check for function and placement was not initialed as complete.  An interview was conducted with Nurse #3 on 3/13/19 at 3:00 PM. She stated she was familiar with Resident #22 and that she had an order for her wanderguard to be checked for function and placement every shift with documentation to be completed on the TAR. She indicated she worked with Resident #22 on 3/9/19 during the 3rd shift. The TAR for 3/9/19 that revealed no documentation by Nurse #3 of Resident #22 ' s wanderguard being checked for function or placement for the 3rd shift was reviewed with Nurse #3. She stated she had completed the task but must have forgotten to initial the TAR on that date. She revealed she had recently received an inservice on the importance of complete and accurate documentation related to wanderguard monitoring. She was unable to explain why she had not completed this documentation.  An interview was conducted with the Director of Nursing (DON) on 3/13/19 at 3:53 PM. She stated that wanderguard monitoring for function and placement was to be completed and documented on the TAR once on the 7:00 AM to 3:00 PM shift, once on the 3:00 PM to 11:00 PM	{F 842}			

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{F 842}	Continued From page 14 shift, and once on the 11:00 PM to 7:00 AM. The DON revealed she was responsible for monitoring the TARs to ensure documentation of wanderguard monitoring was completed three times daily. She stated that she had gotten behind on the monitoring audits this month and had just reviewed the March 2019 TARs on 3/12/19 and identified documentation that was incomplete. The DON also revealed that 7 of 8 residents in the facility with wanderguards had at least once one missed documentation of wanderguard monitoring for function and placement on their March 2019 TAR. She stated that her expectation was for this documentation to be fully completed.	{F 842}			